TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VICTORY MEDICAL CENTER HOUSTON

Respondent Name
TOMBALL REGIONAL HOSPITAL

MFDR Tracking Number
M4-13-1416-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our opinion that our total reimbursement for both the services and the implants should be $64,441.26. To date, all we have received are EOBs denying us for one reason or another."

Amount in Dispute: $53,855.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...preauthorization approval was given by IMO, Respondent's utilization review agent, on March 16 and March 19, 2012 for Removal and Replacement of Spinal Cord Stimulator with 2 leads under Anesthesia with Fluoroscopy Guidance. Requestor did not obtain preauthorization approval for its billed codes in accordance with Division Rule 134.600 prior to providing the health care in dispute. The authorized codes do not support Requestor's use of ICD-9 code [ICD-9] as the primary diagnosis code for CPT Codes J2250, C1820, C1778, C1787, 77003, 95972 and 93005. Furthermore, Requestor's decision for using ICD-9 code [ICD-9 code] based on the rationale that it was 'the diagnosis provided by the physician in his operative note' does not diminish the fact that this code along with the CPT codes noted above were not preauthorized codes for purposes of the March 27, 2012 surgery."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2012	Outpatient facility charges	$53,855.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient hospital facilities.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.

Issues

1. Did the requestor obtain preauthorization for the outpatient hospital services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for outpatient hospitals services rendered on March 27, 2012. The Requestor billed the Respondent $138,200.00 received payment from the Respondent in the amount of $0.00, and is requesting payment in the amount of $53,855.66. The Requestor seeks reimbursement under the 2012 OPPS fee schedule.

   The insurance carrier denied/reduced the disputed services with denial reason(s) code(s), "15 – The authorization number is missing, invalid, or does not apply to the billed services or provider."

   Per 28 Texas Administrative Code §134.600 (p) (12) "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   Per 28 Texas Administrative code §134.600 (a) (7) defines outpatient surgical services as "...surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care."

   Review of the submitted documentation does not support that disputed services, 63663, 93005, 95972, C1820, C1778 and C1883 were preauthorized. As a result, the requestor is not entitled to reimbursement for these disputed services.

   Review of the submitted documentation supports that the requestor obtained preauthorization for disputed services 63650, 63685 and 68688. Therefore these services are reviewed pursuant to Per 28 Texas Administrative Code §134.403.

2. Per 28 Texas Administrative Code §134.403 (f)(1), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section."

   The requestor seeks reimbursement using the following, "According to the OPPS State Fee Schedule, there are two ways a claim can be paid. First would be 200% of the allowed payment rate is we didn't want separate reimbursement for our implants, or no implants were used in the case. The second way, which is the way we requested this claim be paid, is 130% of the allowed payment rate, along with the cost + 10% for implants up to $2,000.00 of ad-on."

   Per 28 Texas Administrative Code §134.403 (e) (3) "Regardless of billed amount, reimbursement shall be: If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   The Requestor acknowledges that the hospital is not a Medicare certified hospital and requests reimbursement by using the 2012 OPPS fee schedule.

   The Division finds that the provisions of Per 28 Texas Administrative Code §134.403 (f) (1) do not apply, as the facility does not have a "Medicare facility specific amount." As a result, this dispute relates to outpatient hospital services with reimbursement subject to 28 Texas Administrative Code §134.1.

   28 Texas Administrative Code §134.1 requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Former Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

3. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "...documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

28 Texas Administrative Code 134.1(f) (2) requires that "fair and reasonable reimbursement" shall "...ensure that similar procedures provided in similar circumstances receive similar reimbursement..." Review of the submitted documentation finds that:

- In support of the requested reimbursement methodology, the requestor seeks reimbursement by utilizing the 2012 OPPS fee schedule.
- The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
- The Division disagrees that the fee guidelines as set forth in §134.403 are "presumptively fair and reasonable reimbursement under the law." No documentation was found to support such a presumption under law.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) ... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
- The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403, effective for dates of service on or after March 1, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

4. The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1(f) (2). Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought for CPT Codes 63650, 63633, 63685 and 68688, would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, reimbursement cannot be recommended for these services.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		January 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date
		January 29, 2016
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.